DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary
Office of the General Counsel
Public Health Division

April 9, 1996

NOTE TO CRAIG VANDERWAGEN

Re: Tribal share distribution for fiscal intermediary funds

I have been asked to comment on a memorandum to the IHS Director proposing a change for calculating tribal shares of the fiscal intermediary function for distribution to the self-governance tribes. The proposed change to a workload methodogy for computing tribal shares would mean increases for some tribes and reductions for others providing reduced amounts for this function to many tribes and consequent reductions in the annual funding agreements for those tribes. The question posed is whether this would run afoul of section 106(b) (2) of the Indian Self-Determination and Education Assistance Act (ISDEA), 25 U.S.C. 450j-1(b)(2), which provides that the amount of funds required by section 106(a) shall not be reduced by the Sectretary in subsequent years except pursuant to five listed circumstances including a reduction in appropriations.

For the reasons indicated below, I believe that the proposed change in methodogy would not be legally barred by section 106(b)(2).

As I understand the situation from the memorandum, tribal shares of the IHS fiscal intermediary function have been added to self-governance funding agreements in accordance with a user population formula. This formula reflects the number of active users of the underlying health services delivery program. There was an exception for the Confederated Salish and Kootenai Tribes (CSKT) for which funding was negotiated on a per claim cost basis. A per claim cost calculation resulted in approximately one thousand percent (1000%) greater funding for the CSKT than the CSKT would have received under the user population formula applied to other self-governance tribes.

The change proposed to the IHS Director would substitute a workload based methodolgy for the user population formula (and per claim cost in the case of the CSKT) for FY 96. A change to a workload formulation would more accurately reflect actual utilization of the fiscal intermediary for claims processing. The memorandum notes that the proposed change will

produce a more equitable distribution and is necessary to reflect "what the Secretary would otherwise provided for this function" under section 106(a)(1) of the Act.

It is also my understanding from the memorandum that the tribal shares for the fiscal intermediary function were paid from the regular IHS Headquarters contract health services budget in fiscal years 1994 and 1995 and not from funds actually supporting the fiscal intermediary function. This was done according to the memorandum because funds had already been obligated for the fiscal intermediary contract and could not be withdrawn from the contract for distribution to the self-governance annual funding agreements.

The IHS fiscal intermediary function is specifically authorized by statute. Section 244 (a)(1) of the Public Health Service Act, 42 U.S.C. 238m(a)(1), states:

> The Secretary may enter into contracts with fiscal agents--
>
> (1)(A) to determine the amounts payable to persons who, on behalf of the Indian Health Service, furnish health services to eligible Indians,
>
> * * * * *
>
> (e) In this section, the term "fiscal agent" means a carrier described in section 1842(f)(1) of the Social Security Act and includes, with respect to contracts under subsection (a)(1)(A), an Indian tribe or tribal organization acting under contract with the Secretary under the Indian Self-Determination Act (Public Law 93-638).

Without this specific statutory authority, the IHS could not use a fiscal intermediary to make CHS payments. Memorandum from Acting General Counsel, GAO to Director, HRD, dated June 6, 1983. (Attached). While section 244(e) of the PHS Act authorizes the Secretary to contract with an ISDA tribe or tribal organization to serve as the government's fiscal agent, it is my understanding that this is not the situation at issue here. The tribe is not serving as the government's fiscal agent for a CHS program operated by the IHS. Rather, compacting tribes are taking their shares of the fiscal intermediary function as an administrative support function to the CHS program operated by the tribe.

As noted above, the IHS reallocated CHS funds to pay for tribal shares of the fiscal intermediary function rather than take funds from the FI contract. The IHS has broad discretion to allocate resources, Lincoln v. Vigil, 113 S. Ct. 2024 (1992), and absent statutory constraints, the IHS can legally reallocate resources to increase the funds for support of the fiscal intermediary function. The reallocation in this instance enabled the self-governance tribes to take their "shares" of the fiscal intermediary function without decreasing funding for the FI

contract.

The issue here is whether section 106(b) of the ISDEA prohibits the IHS from changing what was provided to each self-governance tribe as its share of the fiscal intermediary function. Certainly section 106(b) is applicable in the self-governance context through section 303(a)(6) of Title III which requires that self-governance tribes receive funding equal to what they would have received under a Title I contract. While the purpose of section 106(b) is to provide a stable funding amount for tribal contracting and compacting from year to year, its provisions are subject to an overriding provision at the end of the section which states:

> Notwithstanding any other provision in this Act, the provision of funds under this Act is subject to the availability of appropriations and the Secretary is not required to reduce funding for programs, projects, or activities serving a tribe to make funds available to another tribe or tribal organization under this Act. (Emphasis added).

In addition, allocations for purposes of Title III are subject to section 306 of that title which states:

> Nothing in this title shall be construed to limit or reduce in anyway the servise, contracts or funds that any other Indian tribe or tribal organization is eligible to receive under section 102 or any other applicable Federal law and the provisions of section 110 of this Act shall be available to any tribe or Indian organization which alleges that a funding agreement is in violation of this section.

My understanding of the proposed change to a workload formulation is that it will reflect actual utilization of the fiscal intermediary and thus reflect what the Secretary would have otherwise provided under section 106(a)(1) of the Act. I do not see section 106(b) protecting a tribe against such a result in light of the above quoted provisions.

Duke McCloud

UNITED STATES GOVERNMENT

Memorandum

GENERAL ACCOUNTING OFFICE

June 6, 1983

TO : Director, HRD

FROM : for Acting General Counsel - Harry R. Van Cleve

SUBJECT: Use of Fiscal Intermediaries to Process and Pay Indian Health Service Contracts--B-210545-O.M.

Based on an informal memorandum from the Department of Health and Human Services (HHS), Larry Horinko of your staff asked for legal advice on whether under its current statutory authority the Indian Health Service (IHS) may use fiscal intermediaries to pay the claims of those hospitals which serve the Indian population ("providers") under 42 U.S.C. § 2001(b) (1976). There is presently no such specific statutory authority. For the reasons discussed below, we conclude that legislation authorizing the use of fiscal intermediaries would be required. We understand that HHS will seek legislative authority in its fiscal year 1984 legislation program.

IHS contract health services are services rendered to IHS beneficiaries at IHS expense by non-IHS hospitals and practitioners. IHS authorizes contract services either upon referral of a patient to a contract provider of medical care, or, in cases of emergency, when the patient goes directly to the provider, upon notification as required by regulations (42 C.F.R. § 36.24 (1981)). IHS generally has paid billed charges for the services rendered and bills are currently processed for payment by IHS personnel. The IHS contract care program is authorized under the general authority to conduct the Indian health program, 42 U.S.C. § 2001.

IHS currently has separate contracts with numerous health care providers. During an audit of IHS, HRD staff discovered, based on a sampling, that some 20 percent of the claims paid by IHS employees are either incorrect or are paid twice. HRD staff also observed that the employees frequently failed to thoroughly identify and seek any third party insurance coverage before paying the claims. To correct these problems, HRD staff has suggested that IHS contract out the payment of claims to fiscal intermediaries. As an alternative to IHS contracting out, "piggy back" payments through fiscal intermediaries established under the Health Care Finance Administration's Medicare program, 42 U.S.C. §§ 1395h, 1395u (1976) have been recommended.

Conversion to a system using fiscal intermediaries would allow IHS to contract with an intermediary instead of contracting directly with providers. The intermediary, in turn, would enter into agreements with providers agreeing to participate in this method of reimbursement. The intermediary, pursuant to its contract with the Government, would pay for services authorized by IHS on authorization forms sent to providers and in turn filled out by the providers for filing purposes. IHS would issue the authorization forms upon referral of a patient to a provider or, in cases of emergency when the patient goes directly to the provider, upon proper notification. The intermediaries would also issue monthly reports as well as performing administrative tasks of the sort mentioned above.

For reasons discussed below, it is our view that IHS may not set up a fiscal intermediary program without statutory authority. As HHS itself recognizes, the principle hurdle is that there are statutes which hold disbursing officers personally liable for erroneous payments (31 U.S.C. § 3325, formerly 31 U.S.C. § 82b) and certifying officers personally responsible for the improper certification of vouchers (31 U.S.C. § 3528, formerly 31 U.S.C. § 82c). As we explained in B-201408, April 19, 1982, this Office has consistently opposed any interpretation of these officers' statutory responsibilities that would render them "a matter of form." Speaking particularly of a certifying officer's duties, we said:

> "The certifying officer is personally responsible for determining that the voucher is legally correct and mathematically accurate (B-138602, January 18, 1960); that services have been performed or goods received (39 Comp. Gen. 548 (1960)); that payment thereon is not prohibited by law; and that the voucher represents a valid obligation under the appropriation to be charged (B-193302, December 6, 1978). See also, GAO Policy and Procedures Manual, Chapter 3, section 54 and Chapter 7, section 29. Further, the certifying officer is pecuniarily liable under section 82c for any illegal, improper or incorrect payment unless relieved by the Comptroller General."

As for disbursing officers, they may:

> "* * * disburse moneys only as provided by a voucher certified by (A) the head of the executive

agency concerned; or (B) an officer or employee of the executive agency having written authorization from the head of the agency to certify vouchers * * *."

We have consistently interpreted these statutory designations of responsibility for public funds as requiring that the certifying and disbursing officers be employees of the agency whose funds are to be disbursed. 44 Comp. Gen. 100 (1964). (Exceptions have been made only for Economy Act or similar arrangements under which one agency would be authorized to certify vouchers for another. See, e.g., 50 Comp. Gen. 471 (1980).) Otherwise, strict fiscal accountability for disbursements of public funds would be lost. There is no statutory authority to hold a fiscal intermediary's employees personally liable for errors they may have committed, nor could we hold the Government officer accountable for payments over which he had no control. Thus, even though a certification of the correctness of a payment could be made to a fiscal intermediary under the terms of a contract authorizing the intermediary to pay claims, accountable officers who relied on non-governmental fiscal intermediaries to actually make payments would not be relieved of liability for erroneous payments to beneficiaries or for improper certification of vouchers, in our view. The suggestion by HHS that payments might be provisional would not resolve this problem, as errors in provisional payments still must be attributed to an accountable officer. See B-180264, March 11, 1974.

Because Medicare, 42 U.S.C. §§ 1395h and 1395u, parallels so closely what has been proposed for IHS, the audit staff has asked whether it is possible to use the Medicare authority through the Economy Act, 31 U.S.C. § 1535 (formerly 31 U.S.C. § 686). However, the Economy Act requires that the requisitioning agency, IHS, have independent authority to conduct the transaction in question. Since IHS has no authority to contract for fiscal intermediaries, the Economy Act would not be available under such circumstances.

We also call to your attention the provisions of Office of Management and Budget (OMB) Circular A-76. Under section 5(f), a "governmental function" must be performed in-house "due to a special relationship in executing governmental responsibilities." Certain monetary transactions and disbursements fall within the classification of governmental functions. Monetary transactions and entitlements include "Government benefit programs; tax collection and revenue disbursements by the Government; control of the public treasury, accounts, and money supply; and the administration of public

trusts." Section 5(f)(2) (Emphasis added.) While our Office is not bound, of course, to follow the policies set forth in A-76 if we conclude that a deviation would improve the efficiency and economy of paying claims due under the Indian health services, we should not recommend that IHS depart from the OMB Policy guidance unless the departure has express legislative sanction.

In summary, we conclude that IHS' proposed use of fiscal intermediaries requires legislative authorization prior to implementation of the program. Authority similar to that of the Medicare authority, 42 U.S.C. §§ 1395h and 1395u, with regard to certifying officers and the advance of funds, would appear to meet these needs. Depending upon the actual legislative outcome of such a proposal, IHS might be able to ask the Health Care Finance Administration to process the IHS claims through the Economy Act, supra, although if it has the legislative authority to contract with intermediaries directly, there may be no need to go through the Health Care Financing Administration to achieve the desired results.